Family Health History Questions

Authorized Family Name _____ / / /
Today's Date

ENVIRONMENTAL QUESTIONS *(Answer for your family)*

		No	Yes	Don't Know
1.	Do you live in or regularly visit a house			
	a. With peeling or chipping paint?	☐	☐	☐
	b. With recent, ongoing or planned remodeling?	☐	☐	☐
2.	Do you:			
	a. Live with anyone with lead poisoning?	☐	☐	☐
	b. Work where you are exposed to lead, like in automotive repair, plumbing, pottery?	☐	☐	☐
	c. Live near an active lead smelter, battery recycling plant, or other factories that release lead?	☐	☐	☐

3. Please check (√) all that are true about your household:
   - ☐ Household member employed as a migrant farm worker 802
   - ☐ We have no place to live, no regular night time residence, or live in a shelter. 801-MIHP

FAMILY RESOURCES

		No	Yes	Don't Know
1.	Does your drinking water contain fluoride?	☐ (424 infant, child)	☐	☐
2.	Does anyone in your family take fluoride supplements? If yes, who?_____	☐ (424 infant, child)	☐	☐
3.	Does your family drink well water?	☐	☐	☐
	If yes, has the well water been tested for nitrates?	☐	☐	☐

4. Do you eat fish from Michigan rivers and lakes? ☐ No ☐ Yes

5. How often have you run out of food before the end of the month?
   ☐ Never ☐ Sometimes ☐ Almost always ☐ Rather not answer

6. In the past month, have you ever cut the size of your meals or the family's meals because there was not enough money to buy food?
   ☐ Never ☐ Sometimes ☐ Almost always ☐ Rather not answer

7. Do you receive food stamp benefits? CDC ☐ No ☐ Yes ☐ Rather not answer

8. Would you be interested in learning more about budgeting your food money?
   ☐ No ☐ Yes ☐ Rather not answer

9. Does a family member have a disability that would make it difficult to plan or prepare food for yourself and your family? ☐ No ☐ Yes 902 ☐ Rather not answer

10. Do you have problems with transportation to your prenatal or WIC visits that make it hard for you to come?
    ☐ No ☐ Yes – MIHP

FAMILY MEDICAL INFORMATION

1. Please check (√) all of the following medical issues you or this baby or child has or has ever had:
   If more than one child on WIC, put number from list in box and give name here:
   1) _____
2) 2) _____
3) 3) _____

Baby	*Child*	*Preg.*	*Post-partum*	
☐	☐	☐	☐	Failure to Thrive 134+
☐	☐	☐	☐	Lead Poisoning 211+
☐	☐	☐	☐	Malnutrition, Scurvy, or Beri Beri 341+
☐	☐	☐	☐	Osteomalacia, Cheilosis, or Xeropthalmia 341+
☐	☐	☐	☐	Rickets, Pellagra or Vitamin K Deficiency 341+
☐	☐	☐	☐	Hypocalcemia or Menkes Disease 341+
☐	☐	☐	☐	Ulcer, Malabsorption or Bowel Syndromes 342+
☐	☐	☐	☐	Liver or Gallbladder Disease, Pancreatitis 342+
☐	☐	☐	☐	Diabetes Mellitus 343+
☐	☐	☐	☐	Thyroid Disorders 344+
☐	☐	☐	☐	High Blood Pressure 345+
☐	☐	☐	☐	Kidney (Renal) Disease 346+
☐	☐	☐	☐	Cancer 347+
☐	☐	☐	☐	Cerebral Palsy or Epilepsy 348+
☐	☐	☐	☐	Myelomeningocele or Spina Bifida 348+
☐	☐	☐	☐	Down Syndrome or Cleft Palate/Lip 349+
☐	☐	☐	☐	Muscular Dystrophy 349+
☐	☐	☐	☐	Sickle Cell Anemia or Thalassemia Major 349+
☐	☐	☐	☐	Gastrointestinal Obstruction or Pyloric Stenosis 350+
☐	☐	☐	☐	Phenylketonuria (PKU) or other Inborn Errors of Metabolism 351+
☐	☐	☐	☐	Tuberculosis, Pneumonia, Meningitis 352+ (last 6 months)
☐	☐	☐	☐	Bronchiolitis 352+ (3 episodes in last 6 months)
☐	☐	☐	☐	Parasitic Infections 352+ (last 6 months)
☐	☐	☐	☐	Hepatitis, HIV, AIDS 352+ (last 6 months)
☐	☐	☐	☐	Food Allergies 353+ If yes, describe:_____
☐	☐	☐	☐	Celiac Disease 354+
☐	☐	☐	☐	Lactose Intolerance 355
☐	☐	☐	☐	Hypoglycemia 356+
☐	☐	☐	☐	Major Surgery, Trauma or Burns 359+
☐	☐	☐	☐	Persistent Asthma 352+/360+
☐	☐	☐	☐	Arthritis, Cystic Fibrosis, Lupus 360+
☐	☐	☐	☐	Lung or Heart Disease 360+
☐	☐	☐	☐	Brain Damage or Head Trauma 362+
☐	☐	☐	☐	Pervasive Development Disorder or Autism 362+
☐	☐	☐	☐	Disability that interferes with intake, chewing or swallowing of food 362+
☐	☐	☐	☐	Fetal Alcohol Syndrome (FAS) 382+

Other Problems, please describe:_____ 360+

2. Has anyone in your family had a blood test for lead within the last 12 months? ☐ No ☐ Yes

3. Were any of the results for blood lead level high? ☐ No ☐ Yes
If yes, what was done and for who:_____

PERSONAL SAFETY

1. Are you currently in a relationship where you are physically hurt, threatened or made to feel afraid?
☐ No ☐ Yes

2. Are you afraid to return to where you are living now? ☐ No ☐ Yes

Thank you for completing this form. Please let staff know you are finished.